Child/Minor

(Under 18 years old)

Medical History

Today's Date_____

Name: _____ Preferred name: _____ Birth date: _____

SS#:_____

Street address: _____ City, State, Zip: _____

Mobile phone: (_____)_____ Home phone: (_____)_____

Parent/Guardian name: _____

Relationship to patient (circle one): Mother Father Step-parent Guardian Grandparent

Street address: _____ City, State, Zip: _____

Email address: _____ (appointment reminders only)

Emergency contact: _____ Phone#: _____ Relation: _____

Physician's name: _____ Phone #:_____ Date of last visit: _____

Why have you come to the dentist today? _____

Is patient currently in any pain? □ Yes □ No

Pharmacy name: _____ Location: _____ Phone number: _____

Medications:

Please list **ANY** and **ALL** Medications that the patient is currently taking including prescriptions, over the counter medication, herbal, vitamins and mineral supplements, weight loss aids, cold or allergy medicine, pain medicine, etc:

_____

_____

_____

_____

_____

Girls: Are you taking Birth Control Pills? Yes No

…Hormone Replacement? Yes No

Are you pregnant? Yes No # of Weeks: _____

Are you nursing? Yes No

Do you or have you ever had any of the following diseases or conditions?
(**Please circle either Y or N for each condition**)

Y	N	Diabetes	Y	N	Mitral Valve Prolapse
Y	N	High or Low Blood Pressure	Y	N	Pacemaker
Y	N	Heart Attack	Y	N	Have you been advised to take antibiotics before dental appts?
Y	N	Endocarditis			
Y	N	Rheumatic or Scarlet Fever	Y	N	Heart Surgery
Y	N	Congenital Heart Defect	Y	N	Artificial Heart Valve replacement

Y	N	High Cholesterol	Y	N	Radiation Treatment
Y	N	Stroke	Y	N	Glaucoma or Cataracts (eye problems)
Y	N	Blood Transfusion	Y	N	Sinus Problems
Y	N	Hemophilia/ Abnormal Bleeding	Y	N	Tuberculosis (TB)
Y	N	Anemia	Y	N	Severe/ Frequent Headaches/Migraines
Y	N	HIV/AIDS	Y	N	Emphysema/ Bronchitis
Y	N	Shingles	Y	N	Psychiatric Problems
Y	N	Skin conditions (Psoriasis, etc)	Y	N	Brain or Neural conditions
Y	N	Fever Blisters/ Cold Sores	Y	N	Meningitis viral or bacterial
Y	N	Drug/ Alcohol Abuse	Y	N	Artificial Bones/ Joints (knee, hip etc)
Y	N	Hepatitis	Y	N	Tumors
Y	N	Venereal Diseases/ STD's	Y	N	Kidney Disease
Y	N	Difficulty Breathing, Shortness of Breath	Y	N	Epilepsy/Seizures/Fainting spells
Y	N	Asthma	Y	N	Ulcers/ Colitis/GERD
Y	N	Arthritis (Osteo or Rheumatoid)	Y	N	Hospitalized for any reason
Y	N	Cancer/ Chemotherapy	Y	N	Osteoporosis

Please list and explain any pertinent information and serious medical conditions patient has ever had:

_____

_____

_____

Allergies:

Y	N	Penicillin	Y	N	Dental Anesthetics (Novocain)
Y	N	Aspirin	Y	N	Sulfa drugs
Y	N	Tetracycline	Y	N	Latex
Y	N	Codeine	Y	N	Other

Please list any others not mentioned above including food allergies:

_____

_____

_____

Does the patient smoke? Y N Pks per day: _____ # of Years: _____

Use any other tobacco products? Y N Amount Daily: _____

Type used: Pipe Cigars Snuff Dip Chew Vaping

Type of toothbrush bristles? □ Hard □ Medium □ Soft Use an electric toothbrush? Y N

I acknowledge that the information given today is accurate to the best of my knowledge. I understand that this information will be held in the strictest confidence as outlined by HIPAA guidelines. I am aware it is my responsibility to inform the office immediately of any and all changes in my medical status. I also understand that every insurance policy is different and that I owe the total amount charged to my account regardless of insurance coverage. Any estimates of insurance coverage by Dr. Elias' office are done as a courtesy and are not binding and only my insurance company is able to make a final determination of benefits for my treatment.

X_____ Date: _____

Signed by patient or parent/guardian of minor patients